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## INTRODUCTION

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We welcome you as a member of the EMI Health family and look forward to serving your insurance needs!

EMI Health's dental benefits and administrative procedures are described in this handbook. You are urged to read it carefully, share its contents with the members of your family, and keep it for future reference. If you have any questions or need further information, contact your employer or the EMI Health Customer Service Department.

**This handbook is a summary only**; it is not a contract. Some of the information contained in this handbook may not pertain to your specific plan. Check the "Summary of Benefits" chart for information regarding your benefits or refer to the Group Policy for a more complete description of your coverage. The policy is available for your review from your employer or from EMI Health during regular business hours.

Notwithstanding anything else in the Plan to the contrary, the items listed in the "Dental Plan Exclusion" section are not covered by the Plan.

The Plan will reimburse or pay a claim only if the services rendered are determined to be medically necessary. Determination of medical necessity is made by EMI Health using its own set of criteria, or by an independent contractor appointed by EMI Health.

This is your Plan. Anything you can do to contain costs will help provide additional benefits in the future. We recommend doing the following to assist in the reduction and control of costs:

- Question the need for dental services and visits.
- Be sure all charges are for services actually provided.
- Ask about the price; charges should be competitive.

An Insured who is eligible for Medicare has the right to return this policy for any reason within 30 days, after its delivery and to have the premium refunded.

If you need more information on any of the EMI Health plans or procedures, please call a Customer Service Representative between 8:00 a.m. and 5:00 p.m., Monday through Friday (MT):

(801) 270-2880 in Salt Lake City or  
(800) 662-5852 elsewhere in the Continental U.S.A.

### **Plan Administrator**

EMI Health Choice Plans are administered and underwritten by Educators Health Plans Life, Accident, and Health, Inc.



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## EMI HEALTH CHOICE DENTAL PLAN

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This section provides a general summary of benefits available under the Plan. For details as to specific coverage, see the “Summary of Benefits” chart.

### **Diagnostic/Preventive Benefits**

- Oral examinations two times per year.
- X-rays are covered as follows:
  - Full mouth – once every three years
  - Supplementary bitewings – up to four procedures, twice per year
  - Supplementary periapical – six procedures per year
- Cleaning and scaling teeth (prophylaxis) two times per year.
- Application of fluoride in conjunction with cleaning two times per year, limited to Dependent children up to the age specified on the “Summary of Benefits” chart.

### **Space Maintainers**

- Space maintainers used to maintain the present position of a tooth following an extraction for Dependent children up to the age specified on the “Summary of Benefits” chart.

### **Sealants**

- Sealants for Dependent children up to the age specified on the “Summary of Benefits” chart.

### **Basic Services**

- Restoration of decayed teeth with amalgam, synthetics, or plastic, up to one restoration per surface. Repairs to restorations are allowed only once every 18 months, regardless of the reason. Tooth preparation, temporary restorations, cement bases, impressions, and local anesthesia are all considered part of the restoration and are covered only when included in the charge for the entire process.

### **Major Services**

- Gold onlays and crowns are covered if teeth cannot be restored with amalgam, synthetic, porcelain, or plastic. Benefits are payable once every five years for the same tooth.

### **Endodontic Services**

- Endodontic treatment, including root canal therapy. One pulp cap per tooth is allowed. Bases are not covered.

### **Periodontic Services**

- Periodontic services are limited to one perio maintenance (two per year in lieu of preventive cleaning); root scaling and planing (once per quadrant of mouth in any 24 month period); gingivectomy, gingival curettage; osseous surgery including flap entry and closure; pedicle or free soft tissue grafts; full mouth debridement (one every five years).

### **Prosthodontic Services**

- Initial installation of a removable or fixed partial or complete denture once every five years. Fixed bridges for patients under age 16 are covered up to the amount allowed for a removable partial denture.

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- One laboratory reline is covered following the initial installation of a denture and once every three years thereafter. Office relines are not a covered benefit.
  - Implants are covered, unless otherwise indicated on the “Summary of Benefits” chart. All services and products related to the implant (including, but not limited to, the anchor, and the post) apply toward the implant limit. Crowns associated with implants fall under the benefit for crowns and are subject to any limits applicable to that benefit. (These benefits are limited. Check the “Summary of Benefits” chart for details.)
  - Replacement of missing teeth with complete or partial dentures or fixed bridge is covered.
  - Replacement of a denture that is no longer serviceable is covered once every five years.

### **Oral Surgery Services**

- Extractions and other oral surgery involving procedures for simple and complicated extractions of impacted or erupted teeth, including frenectomy, alveolectomy, removal of palatal and mandibular tori, and crown exposure. Post-operative care and removal of sutures are considered part of the surgical procedure and are covered only when included in the charge for the entire surgical procedure.

### **Anesthesia Services**

Not all plans have anesthesia services. Check the “Summary of Benefits” chart for details.

- General anesthesia, including intravenous sedation, is limited to age seven and under, once per year. General anesthesia for the extraction of impacted teeth for individuals age eight and over is covered to the Table of Allowances, based on necessity, not for anxiety management.

### **Orthodontic Services**

Not all plans have orthodontic benefits. Check the “Summary of Benefits” chart for details.

Orthodontic services are covered for functionally related problems, not for Cosmetic purposes, for eligible unmarried Dependent children up to the applicable age indicated on the “Summary of Benefits” chart and adult contract holders and their Spouse if indicated on the “Summary of Benefits” chart.

- Initial diagnostic records (study models, facial photographs, etc.) are covered only if eligible orthodontic treatment is rendered.
- Orthodontic treatment, including diagnostic procedures, X-rays, and appliance therapy.
- Amounts paid under a previous dental care plan for a case in progress, which is defined as the placement of bands, will be deducted from the maximum amount payable for orthodontic benefits under this Plan. (Check with EMI Health or the Policyholder for further details.)

### **Waiting Periods**

Benefits for some service types may be subject to waiting periods. Please see the “Summary of Benefits” chart for details of your Plan.

### **Predetermination of Benefits**

Before starting a dental treatment for which the charge is expected to be \$300 or more, a predetermination of benefits is recommended.

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The Dentist must itemize all recommended services and costs and attach all supporting documents, including x-rays.

The Plan will notify the Dentist of the benefits payable under the Plan. The Insured and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

**Alternate Treatment**

Many dental conditions can be treated in more than one way. This Plan has an alternate treatment clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient receives a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

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## CHOICE DENTAL PLAN EXCLUSIONS

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Notwithstanding anything else in the Plan to the contrary, the items listed below are not covered by the Plan.

EMI Health Choice Dental Plan does not pay for any of the following:

1. Services received by an Insured before coverage under the Plan became effective or after coverage under the Plan has terminated.
2. Expenses for preparing dental reports, itemized bills, or claim forms.
3. Illness or injury caused by the negligent or wrongful act of another, or for which the Insured is covered by any workers' compensation or similar law; except that EMI Health may advance benefits to or on behalf of the Insured in such situations, subject to EMI Health's right of Subrogation and reimbursement set forth herein.
4. Illness or injury that an Insured incurred either (1) while in the service of an employer that was obligated by law to provide workers' compensation insurance that would have covered such illness or injury, or, (2) while in the service of an employer that had elected to exclude workers' compensation coverage for such Insured, except that EMI Health may elect to advance benefits to or on behalf of the Insured in either situation, subject to EMI Health's rights of Subrogation and reimbursement set forth herein.
5. Illness or injury for which the Insured is covered by other responsible insurance including, but not limited to, coverage under a government sponsored health plan, underinsured motorist coverage, or uninsured motorist coverage, except as otherwise provided herein, or as otherwise provided by law.
6. Charges for services related to birth defects or cosmetic surgery or dentistry for solely Cosmetic reasons including, but not limited to, bonding and veneers.
7. Any procedure started prior to the date the patient became covered for such services under this policy. This Exclusion does not apply to orthodontic benefits for a case in progress.
8. Medical care, confinement, treatment, services, use of facilities, or supplies for which charges are made by a facility, including freestanding nursing home, rest home, or similar establishment.
9. Plaque control programs, oral hygiene instruction, and dietary instruction.
10. Myofunctional therapy.
11. Lab costs for an oral tissue biopsy.
12. Treatment to correct problems with the way teeth meet or to adjust bite (alter vertical dimensions or restore or equilibrate occlusion) except as covered under orthodontia.

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13. Care, treatment, operations, supplies, appliances, aids, devices, or drugs that are not FDA approved.
  14. Any loss caused, or contributed to, by the Insured committing, or attempting to commit, a criminal act. This Exclusion does not apply to benefits for victims of domestic violence or for Insureds with mental health conditions.
  15. Care, treatment, operations, or supplies that are illegal, Experimental, Investigative, or for research purposes by the United States medical profession that are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted dental/medical practices.
  16. Expenses in connection with transportation or mileage reimbursement.
  17. Expenses including, but not limited to, air fare, meals, accommodations, and car rental.
  18. Medications labeled “Caution, Limited by Federal Law to Investigational Use” or experimental drugs. Twelve months must have passed after FDA approval, before the Plan will consider coverage.
  19. Services that are not Medically Necessary or Cosmetic Treatment including veneers, special techniques, precious metals used for removable appliances other than orthodontics, precision attachments for partial dentures or bridges, and personal characterization.
  20. Any procedure or appliance to correct or treat temporomandibular joint dysfunction (TMJ).
  21. Dental implants (unless otherwise indicated), transplants, reimplantations, and associated appliances or services rendered in conjunction with implants. This Exclusion does not apply to otherwise covered crowns.
  22. Hospital services.
  23. Habit-breaking devices or appliances to correct thumb sucking, tongue thrusting, etc.
  24. Temporary restorations, appliances, or procedures of any nature, except that temporary restorations are covered when included in the charge for the restoration process.
  25. Replacement of lost, stolen, or damaged dentures, except once every five years.
  26. Procedures, appliances, or restorations, other than those for replacement of structure loss from caries, that are necessary to alter, restore, or maintain occlusion by any of the following: realignment of teeth, periodontal splinting, gnathological recordings, equilibration, treatment of disturbances of the temporomandibular joint (TMJ), orthognathic procedures.
  27. Hypnosis and related analgesia.

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28. Restorative dental services in connection with an overdenture.
  29. Expenses for services required due to complications associated with, or due to, non-covered services, and where applicable, reversal of non-covered services.
  30. Services rendered by anyone other than a licensed Dentist and when necessary and customary, as determined by the standards of generally accepted dental practice.
  31. Services for injury resulting from war or any act of war, whether declared or undeclared.
  32. Care, treatment, or services the Insured is not, in the absence of this policy, legally obligated to pay, except as otherwise provided by law.
  33. Care, treatment, or services rendered by any Provider who ordinarily resides in the same household (e.g. Spouse, parent).
  34. Benefits for services or treatments covered under any medical plan.
  35. Expenses for appointments scheduled but not kept, or for telephone consultations.
  36. Expenses for shipping, handling, postage, sales tax, interest, or finance charges.
  37. Charges for completion or submission of insurance forms.
  38. Prescription drugs and over-the-counter medication.
  39. Charges for care, treatment, or surgical procedures that are unnecessary or in excess of the Summary of Benefits or the Table of Allowance.
  40. The application of a dental sealant on any tooth that has been previously treated with a temporary or permanent restoration.
  41. The application of dental sealants on all Anterior teeth whether Deciduous or permanent teeth.
  42. Chemotherapeutic injections.
  43. Orthodontic expenses, unless otherwise indicated on the "Summary of Benefits" chart.
  44. All other services not specified as covered benefits or not specifically included in the contract with the Employer.

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## ELIGIBILITY AND PARTICIPATION

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### Plan Administration

The EMI Health Choice Dental Plan is administered and underwritten by Educators Health Plans Life, Accident, and Health, Inc.

### Eligibility

An Employee and his Dependents are eligible for participation and coverage under this Plan if the Employee is a Full-time Employee of the Employer. Dependents of the Employee eligible for coverage include Dependent children from birth to the 26<sup>th</sup> birthday and the Employee's Spouse. Children may include stepchildren, children placed for adoption, legally adopted children, and children for whom the Employee has legal guardianship. Coverage for an adopted child of a Subscriber is provided from the moment of birth, if placement for adoption occurs within 30 days of the child's birth, or beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth. Coverage ends if the child is removed from placement prior to being legally adopted. A Dependent child's coverage may be extended beyond the 26<sup>th</sup> birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is chiefly dependent on the Subscriber for support and maintenance. The Subscriber must furnish written proof of disability and dependency to EMI Health within 31 days after the child reaches 26 years of age. In addition, upon application, the Plan will provide coverage for all disabled Dependents who have been continuously covered, with no break of more than 63 days, under any accident and health insurance since the age of 26. EMI Health may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually. (Please refer to Dependent in the "Definition of Terms" section for more information.)

### Changes in Insured Information

Subscribers should notify EMI Health within 31 days whenever there is a change in an Insured's situation that may affect the Insured's enrollment eligibility or status.

### Enrollment

To enroll, the Employee must complete an enrollment application and file it with his Employer within 31 days of his employment date, or during a subsequent Open Enrollment period. A Subscriber is not entitled to change his coverage elections during the plan year, except as provided in the *Special Enrollment* section

### When Coverage Begins

If the Employee enrolls within 31 days of his employment, the Employee's coverage (and the coverage of his eligible Dependents, if such Dependents were also enrolled during such 31-day period) becomes effective as determined by the Employer. If the Employer imposes any waiting period prior to the start of coverage, such waiting period will not satisfy the benefit category waiting periods, if any.

If the Employee enrolls during an Open Enrollment period, the Employee's coverage (and the coverage of his eligible Dependents, if such Dependents were also enrolled during such Open Enrollment period) becomes effective the first day of the following plan year.

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If the Employee enrolls during a Special Enrollment period, the Employee's coverage (and the coverage of his eligible Dependents, if such Dependents were also enrolled during such Special Enrollment period) becomes effective as provided in the *Special Enrollment* section.

## **Special Enrollment**

### **Special Enrollment Period When Other Coverage Terminates**

If an Employee declined participation for himself and/or his eligible Dependents and, when enrollment was previously declined, the Employee and/or his eligible Dependents were covered under another group plan or had other insurance coverage, the Employee will have a Special Enrollment period if when the Employee declined enrollment for himself and/or his eligible Dependents, the Employee and/or his eligible Dependents

1. Had COBRA continuation coverage under another plan and such continuation coverage has since been exhausted, and the Employee elects coverage for himself or herself and/or his or her eligible Dependents by making an election with the Policyholder, in the manner prescribed by the Policyholder within 31 days of such cessation; or
2. Had coverage through Medicaid or the Children's Health Insurance Program (CHIP) that has been terminated as a result of loss of eligibility of coverage, and the Employee elects coverage for himself or herself and/or his or her eligible Dependents by making an election with the Policyholder, in the manner prescribed by the Policyholder within 60 days of such cessation; or
3. If the other coverage was not under COBRA, Medicaid, or CHIP, either the other coverage has been terminated as a result of loss of eligibility of coverage or employer contributions towards such coverage have been terminated, and the Employee elects coverage for himself or herself and/or his or her eligible Dependents by making an election with the Policyholder, in the manner prescribed by the Policyholder within 31 days of such cessation. (**Note:** Loss of eligibility of coverage includes a loss due to legal separation, divorce, death, termination of employment, reduction in hours worked, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or intentional misrepresentation of a material fact.)

If the Employee meets the above conditions, coverage under the Plan will be effective as of the date such previous coverage ceased.

### **Special Enrollment Period for Approval to Receive Premium Assistance**

The Employee and his eligible Dependent may enroll for coverage (even if He previously declined coverage for himself and/or his eligible Dependents) if the Employee is approved to receive a Premium Assistance. To enroll during this Special Enrollment period, the Employee must enroll in the Plan within 60 days from the date on which He receives written notification that He is eligible to receive Premium Assistance. Coverage will be effective the first day of the month immediately following enrollment. This provision does not modify any requirement related to premiums or Preexisting Condition Waiting Periods that apply under the Plan to a similarly situated eligible Employee or Dependent.

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### **Special Enrollment Period for Acquisition of Dependent**

The Employee and/or his new eligible Dependent may enroll for coverage (even if He previously declined coverage for himself and/or his eligible Dependents) if the Employee acquires such new eligible Dependent due to marriage, birth, adoption, or placement for adoption. In addition, the Employee may also enroll his Dependent Spouse if the Employee acquires a new Dependent due to marriage, birth, adoption, or placement for adoption. To enroll during this Special Enrollment period, the Employee must enroll within 31 days of the event (e.g., marriage, birth, adoption, or placement for adoption). Coverage will be effective as follows:

1. In the case of marriage, the marriage date; or
2. In the case of an eligible Dependent's birth, the date of such birth, or
3. In the case of adoption, or placement for adoption, the coverage for an adopted child of a Subscriber is provided from the moment of birth, if placement for adoption occurs within 30 days of the child's birth, or beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

### **Termination of Coverage**

Unless eligible for continuation coverage under COBRA, an Insured's participation under the Plan ceases on the earliest of the following:

- For the Subscriber and covered Dependents, the last day of the calendar month coinciding with, or following the Subscriber's termination of employment or when the Subscriber's employment position or status changes such that He is no longer a Full-time Employee, unless specific provisions in the Employer Group's policy manual apply;
- For the Subscriber and covered Dependents, the last day of the month for which coverage has been paid, in the event any required Subscriber contributions are not made (subject to the 31-day Grace Period);
- For covered Dependents, other than the Subscriber's Spouse, the individual ceases to be an eligible Dependent on the last day of the calendar month coinciding with the Dependent's 26<sup>th</sup> birthday;
- For covered Spouse, the last day of the calendar month coinciding with the date the divorce from the Subscriber is final;
- For the Subscriber and covered Dependents, the date specified in any Plan amendment resulting in loss of eligibility;
- For the Subscriber and covered Dependents, the date this Plan is terminated; and
- For any Insured, the discovery of fraud or intentional material misrepresentation of material fact on the part of the Insured in either the enrollment process or in the use of services or facilities. (Note: If an Insured's coverage is terminated under this provision based on fraud, the termination of coverage will relate back to the effective date of coverage and EMI Health may recover any overpayments from the Insured such that EMI Health and the Insured are returned to the same financial position as if no coverage had ever been in force.

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If the Insured's coverage is terminated under this provision based on intentional material misrepresentation of material fact, the termination of coverage will relate back to the date the misrepresentation occurred and EMI Health may recover any overpayments from the Insured. Termination of a Subscriber's coverage for cause will also result in the termination of coverage of the Subscriber's covered Dependents.)

A Subscriber is not entitled to voluntarily terminate coverage for himself or his covered Dependents during the plan year, unless he experiences a Special Enrollment qualifying event (e.g. marriage, divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage). If the Subscriber experiences a Special Enrollment qualifying event, he may elect to terminate coverage for himself and/or his Dependents by making an election with the Policyholder, in the manner prescribed by the Policyholder, within 31 days of such event.

### **Family Medical Leave Act (FMLA)**

A Subscriber who goes on a leave under the Family Medical Leave Act (FMLA) has the following rights during such leave:

- A Subscriber may continue his coverage and the coverage of his covered Dependents during an FMLA leave provided the Subscriber continues to pay any required Employee portion of the cost of coverage in accordance with the Employer's FMLA leave policy. The Employer shall continue to make the same contributions toward that coverage that it would have made had the Subscriber not taken FMLA leave.
- If premiums are not paid, the Subscriber's and covered Dependents' coverage will be terminated 31 days after the due date of any required payment. Upon the Subscriber's return to work, the Subscriber's coverage and the coverage of any previously covered Dependents will be reinstated as long as the Subscriber returns to work before or following the expiration of the FMLA leave. If the Subscriber does not return to work before or following the expiration of the FMLA leave, the Subscriber will be treated as a new Employee upon his return and will be entitled to elect coverage for himself and his eligible Dependents in accordance with the rules applicable to new Employees.

### **Military Leave**

Pursuant to the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), a Subscriber who is on military duty with a uniformed service has certain rights. If the period of duty is less than 31 days, coverage will be maintained if the Subscriber pays any required Subscriber contribution. If the period of duty is for more than 31 days, EMI Health must permit the Subscriber to continue coverage under rules similar to COBRA. The maximum coverage period is the lesser of 24 months or the period of duty. A Subscriber receiving coverage under USERRA shall be required to pay 102 percent of the applicable premium. No waiting period can be imposed on a returning Subscriber and his Dependents if the period would have been satisfied had the Subscriber's coverage not terminated due to the duty leave.

### **Qualified Medical Child Support Orders**

Upon receipt of a National Medical Support Notice requiring the Subscriber to provide coverage for a Dependent child, EMI Health will comply with all applicable requirements of the Notice and applicable law.

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## Your Rights Under ERISA

If you are covered by an ERISA plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all Insureds shall be entitled to the following:

- Receive information about your Plan and benefits
  - Examine, without charge, at the Plan administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the public disclosure room of the Employee Benefits Security Administration.
  - Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan administrator may make a reasonable charge for the copies.
  - Receive a summary of this Plan’s annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.
  
- Continue group health Plan coverage
  - Continue health care coverage for yourself, your Spouse, or eligible Dependents, if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible Dependents may have to pay for such coverage. Review this document for the rules governing your COBRA continuation coverage rights.
  - Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a group health plan, if you have creditable coverage from another plan. For instance, if, after your participation in this Plan ceases, you obtain coverage under another group health plan, you have the right to demonstrate creditable coverage by presenting a certificate of coverage from this Plan. You are entitled to request a certificate of creditable coverage from this Plan for yourself or for any of your eligible Dependents who were enrolled under this Plan. Request should be made within 24 months after the loss of coverage under this Plan. You also have the right to demonstrate creditable coverage through documentation other than a certificate of creditable coverage, such as an explanation of benefits, correspondence from the Plan indicating prior coverage, or a health insurance card. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for up to 12 months (18 months for Late Enrollees) in your new group health plan after your enrollment date.
  
- Prudent action by Plan fiduciaries
  - In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate this Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of participants and other Plan participants and beneficiaries. No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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- Enforce your rights

- If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse this Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds the person's claim is frivolous).

- Assistance with your questions

- If you have any questions about this Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed below or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The following is a listing of the Employee Benefits Security Administration, U.S. Department of Labor, offices:

Atlanta Regional Office  
61 Forsyth St. SW, Ste 7B54  
Atlanta, GA 30303 (404) 562-2156

Boston Regional Office  
One Bowdoin Square, 7<sup>th</sup> Floor  
Boston, Ma 02114 (617) 424-4950

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Chicago Regional Office  
200 W Adams St., Ste 1600  
Chicago, IL 60606 (312) 353-0900

Cincinnati Regional Office  
1885 Dixie Highway, Ste 210  
Ft. Wright, KY 41011-2664 (606) 578-4680

Dallas Regional Office  
525 Griffin St., Room 707  
Dallas, TX 75202-5025 (214) 767-6831

Detroit District Office  
211 West Fort St., Ste 1310  
Detroit, MI 48226-3211 (313) 226-7450

Kansas City Regional Office  
City Center Square  
1100 Main, Ste 1200  
Kansas City, MO 64105-2112 (816) 426-5131

Los Angeles Regional Office  
790 E. Colorado Blvd., Ste 514  
Pasadena, CA 91101 (818) 583-7862

Miami District Office  
111 NW 183<sup>rd</sup> St., Ste 504  
Miami, FL 33169 (305) 651-6464

New York Regional Office  
1633 Broadway, Room 226  
New York, NY 10019 (212) 399-5191

Philadelphia Regional Office  
Gateway Building  
3535 Market St., Room M300  
Philadelphia, PA 19104 (215) 596-1134

St. Louis District Office  
815 Olive St., Room 338  
St. Louis, MO 63101 (314) 539-2691

San Francisco Regional Office  
71 Stevenson St., Ste 915, P.O. Box 190250  
San Francisco, CA 94119-0250 (415) 975-4600

Seattle District Office  
111 Third Ave., Ste 860 MIDCOM Tower  
Seattle, WA 98101-3212 (206) 553-4244

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Washington D.C. District Office  
1730 K St. NW, Ste 556  
Washington D.C. 20006 (202) 254-7013

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## CONTINUATION OF COVERAGE

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### **COBRA Continuation of Coverage Requirements**

Under the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), an Insured who could otherwise lose coverage as a result of a “qualifying event” is entitled to elect to purchase medical continuation under the Plan. The coverage will be identical to the coverage provided to Insureds to whom a qualifying event has not occurred.

- **Qualifying Event.** A “qualifying event” is any of the following:
  - For an Employee, termination of employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage;
  - For a Spouse and eligible Dependents, death of the Employee;
  - For a Spouse, divorce or legal separation;
  - For a Spouse and eligible Dependents, loss of coverage due to the Employee becoming eligible for Medicare;
  - For a Dependent child, ceasing to qualify as a Dependent under the Plan;
  - For retirees and their Dependents, employer bankruptcy under Chapter 11.

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## COORDINATION OF BENEFITS WITH OTHER GROUP PLANS

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### **Coordination with Other Group Plans**

When an Insured is covered by this Plan and another COB Plan, one plan is designated as the Primary Plan. The Primary Plan pays first and ignores benefits payable under the other plan. The Secondary Plan reduces its benefits by those payable under the Primary Plan.

Any COB Plan that does not contain a Coordination of benefits provision that is consistent with Utah Rule R590-131 (Non-conforming Plan) will be considered primary, unless the provisions of both plans state that the Conforming Plan is primary. Refer to Plan document for full details on Coordination of Benefits with other group plans.

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## CLAIMS PROCEDURE

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Except as otherwise provided in this policy or by Utah law, no benefits provided under this policy shall be paid to, or on behalf of, an Insured unless the Insured, or his authorized representative, has first submitted a written claim for benefits to EMI Health. Claims may be submitted at any time within 12 months of the date the expenses are incurred. If, however, the Insured shows that it was not reasonably possible to submit the claim within that time period, then a claim may be submitted as soon as reasonably possible.

### How to File a Claim

Submit properly completed and coded Provider bills to the following address:

EMI HEALTH  
852 East Arrowhead Lane  
Murray, Utah 84107-5298

If the claim form is not properly completed, it cannot be processed, and it will be returned.

### Requests for Additional Information

There are times when claims submitted in the Insured's behalf may not contain sufficient information for EMI Health to process them correctly. In those situations, EMI Health will request additional information from the Insured or the Provider. EMI Health is likely to request information directly from the Insured for the following reasons:

- To obtain details of an Accident.
- To expedite coordination of benefits.
- To conduct an audit.

Insureds can expedite the processing of their claims by providing the requested information as quickly as possible, and in as much detail as possible.

### Exhaustion of Administrative Remedies

No action at law or in equity may be brought against EMI Health or the plan administrator, and no arbitration request may be made, until the Insured has exhausted the claims review process, as provided in this policy.

### Appointment of Authorized Representative

The Insured may appoint an authorized representative to act on his behalf in pursuing a benefit claim or appealing an adverse benefit determination. The Insured shall appoint the authorized representative by signing an "Appointment of Authorized Representative" form available from EMI Health, with the authorized representative accepting such appointment by signing the "Appointment of Authorized Representative" form. The Insured desiring to appoint an authorized representative shall submit the fully executed form to the Plan administrator.

### Claims Review Process

If EMI Health denies payment of a claim which an Insured believes is properly compensable under the applicable terms of the Plan, the Insured shall within the time limits provided in subparagraphs one through five below after receipt of notice of denial of payment or coverage take the matter up with **EMI Health's claims review committee**, which shall be composed of at

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least three employees of EMI Health who did not participate and are not supervised by any person who participated in the initial decision. If agreement is not reached on the claim, the Insured shall within the time limits provided in subparagraphs one through five below after the decision of the claims review committee have the right to request a second level appeal regarding the disputed claim and an in-person hearing by **EMI Health board of directors**, which shall include at least one consumer representative. This request must be in writing and must be received by EMI Health within the time limits provided in subparagraphs one through five below after receipt of notice indicating the decision of the claims review committee. The EMI Health board of directors notice of decision will inform the Insured of its decision and, if adverse to the Insured, the basis of its decision in writing. If the Insured disagrees with the decision of the EMI Health board of directors in the second level appeal, the Insured shall have a **right to submit the matter to binding arbitration or to pursue any remedies available at law or equity**. If the Insured elects binding arbitration, then all relevant information and the positions of all parties shall be submitted to the arbitrator, who shall then review the matter and make a decision which is final and binding on EMI Health and the Insured. In no event shall the arbitrator have the power to extend or expand upon the provisions of the Plan. The procedure for arbitration shall be as provided in the *Arbitration* provision of this Plan.

EMI Health will observe time limits, provide notices, and administer appeals in accordance with subparagraphs one through five below.

1. EMI Health will provide a notice of its initial claim decision within (a) 30 days after receiving the initial claim, or (b) 45 days after receiving the claim if EMI Health determines that such an extension is necessary due to matters beyond the control of the Plan and if EMI Health provides an extension notice during the initial 30-day period. If the extension is due to the Insured's failure to submit sufficient information necessary to decide a claim, the extension notice shall specify the additional required information and the Insured will have at least 45 days to provide the additional information. The period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent until the date on which the Insured provides the additional required information.
2. If EMI Health denies the claim in whole or in part, the Insured has 180 days after receiving notice of the claim denial to appeal the decision in writing.
3. The claims review committee will provide notice of its decision on appeal within 30 days after receiving the request for appeal.
4. If the claims review committee denies the claim in whole or in part, on appeal, the Insured has 180 days after receiving notice of the denial to request a second level appeal in writing.
5. The board of directors will provide notice of its decision on the second level of appeal within 30 days after receiving the notice of appeal to the board.

### **Independent Review of Medical Necessity**

If, after exhaustion of the claims review process provided in this Plan, the Insured still disputes a determination of Medical Necessity, the Insured shall have the voluntary option to submit the adverse benefit determination of Medical Necessity for an independent review.

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The Insured may initiate such independent review of Medical Necessity by giving written notice to EMI Health of the Insured's election to proceed with independent review within 180 days from the date of the receipt, in writing, from EMI Health of the final adverse benefit determination of Medical Necessity from the claims review process.

If the Insured timely elects the above independent review, then EMI Health will inform the Insured in writing, of the decision of the IRO, within 60 days after the date EMI Health received the Insured's written request for independent review of Medical Necessity.

### **Arbitration**

ANY MATTER IN DISPUTE BETWEEN YOU AND THE COMPANY MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE COMPANY. THE COMPANY SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES, AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

If, after exhaustion of the claims review process provided in this Plan, the Insured still disputes the results of the same, the subject claim, controversy, or dispute may be submitted for resolution through binding arbitration in accordance with the provisions hereof.

The Insured may initiate arbitration proceedings by giving written notice to EMI Health of the election to proceed with binding arbitration within 180 days after the delivery in writing of the final adjudication from the claims review process.

### **Benefit Accumulations**

All Deductibles, benefit limits, etc., except for the Lifetime Maximum Benefit, accumulate on a Contract- or Calendar- Year basis. All annual maximums are combined for a total of \$2,000.00. Eligible Expenses in connection with treatment received from any provider (Advantage Plus, Premier, and Out-of-Network) are combined for a specified dollar amount (as defined in the "Summary of Benefits" chart) each year. Once annual benefits exceed that specified dollar amount, only Eligible Expenses received from Advantage Plus Dentists will be considered. There will be no additional benefit for Premier or Out-of-Network Dentists. (Check with EMI Health or the Policyholder for accumulation dates and dollar limits.)

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## DEFINITION OF TERMS

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***Accident and Accidental Injury***, for which benefits are provided, means Accidental bodily Injury sustained by the Insured which is the direct result of an Accident, independent of disease or bodily infirmity or any other cause.

***Actively at Work or Active Work*** means being in attendance at the customary place of employment, performing the duties of employment on a Full-time Basis, and devoting full efforts and energies in the employment.

***Allowable Expenses***, when used in conjunction with Coordination of Benefits, shall have the same meaning as the term “Allowable Expenses” in Utah Rule R590-131-3.A.

***Anterior*** means the teeth and tissues located towards the front of the mouth; maxillary and mandibular incisors and canines.

***Calendar Year*** means the 12-month period beginning January 1 and ending December 31.

***COB Plan***, means a form of coverage with which Coordination of Benefits is allowed. These COB Plans include the following:

- Individual, and group accident and health insurance contracts, and subscriber contracts, except those included in the following paragraph.
- Uninsured arrangements of group or group-type coverage.
- Coverage through closed panel plans.
- Group-type contracts.
- Medical care components of long-term care contracts, such as skilled nursing care.
- Medicare or other governmental benefits, as permitted by law.

The term COB Plan does not include any of the following:

- Hospital indemnity coverage benefits or other fixed indemnity coverage.
- Accident-only coverage.
- Specified disease or specified Accident policies.
- Limited benefit health coverage, as defined in Utah Rule R590-126.
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a “to and from school” basis.
- Benefits provided in long-term care insurance policies for non-medical services.
- Any state plan under Medicaid.
- A government plan, which by law, provides benefits that are in excess of those of any private insurance or other non-governmental plan.
- Medicare supplement policies.

The term COB Plan is construed separately with respect to each policy, contract, or other arrangement for benefits or services. The term COB Plan may also mean a portion of a policy, contract, or other arrangement which is subject to a Coordination of Benefits provision, as separate from the portion which is not subject to such a provision.

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**COBRA Administrator** means the entity selected by the Policyholder to administer COBRA benefits. See Policyholder for COBRA Administrator contact information.

**Coinsurance** means the percentage of eligible charges payable by an Insured directly to a Provider for covered services. Coinsurance percentages are specified on the “Summary of Benefits” chart.

**Conforming Plan** means a COB Plan that is subject to Utah Rule R590-131.

**Contract Year** means the 12-month period following the effective date of this policy and any 12-month period following that date.

**Coordination of Benefits** means a provision establishing an order in which plans pay their Coordination of Benefits claims, and permitting Secondary Plans to reduce their benefits so that the combined benefits of all plans do not exceed total Allowable Expenses.

**Copayment** or **Copay** means, other than coinsurance, a fixed dollar amount that an Insured is responsible to pay directly to a Provider. Copayment amounts are specified on the “Summary of Benefits” chart.

**Cosmetic Treatment** means any procedure performed to improve appearance or correct a congenital deformity that does not affect function.

**Deciduous** means having the property of falling off or shedding; a name used for the primary teeth.

**Deductible** means the amount paid by an Insured for Eligible Expenses from the Insured’s own money before any benefits will be paid under this policy.

**Dentist** means a duly licensed Dentist legally entitled to practice dentistry at the time, and in the place, services are performed.

**Dependent** means the Subscriber’s children (including legally adopted children and children for whom the Participant has legal guardianship) to their 26<sup>th</sup> birthday. A child is considered a Dependent beyond the 26<sup>th</sup> birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is dependent on the Subscriber for support and maintenance. The Subscriber must furnish proof of disability and dependency to EMI Health within 31 days after the child reaches 26 years of age. In addition, upon application, the Plan will provide coverage for all disabled Dependents who have been continuously covered, with no break of more than 63 days, under any accident and health insurance since the age of 26. EMI Health may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually. Dependent also refers to any of the Subscriber’s natural children, children placed for adoption, or adopted children for whom a court order or administrative order has dictated that the Subscriber provide coverage. Dependent also refers to the Subscriber’s Spouse. Dependent does not include an unborn fetus.

**Eligible Expenses** means those charges incurred by the Insured for illness or injury that meet all of the following conditions:

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- Are necessary for care and treatment and are recommended by a Provider while under the Provider's continuous care and regular attendance.
  - Do not exceed the EMI Health Summary of Benefits or Table of Allowances for the services performed or materials furnished.
  - Are not excluded from coverage by the terms of this policy.
  - Are incurred during the time the Insured is covered by this policy.

**EMI Health** means Educators Health Plans Life, Accident, and Health, Inc.

**Employee** means a Full-time Employee or an elected or appointed officer of the Policyholder. Employees must be legally entitled to work in the United States.

**Employer** means Policyholder.

**Enrollment Date** means the first day of coverage, or if there is a waiting period before coverage takes effect, the first day of the waiting period.

**Exclusion** means the policy does not provide insurance coverage, for any reason, for one of the following:

- A specific physical condition;
- A specific medical procedure;
- A specific disease or disorder; or
- A specific prescription drug or class of prescription drugs.

**Experimental or Investigative** means medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices, which are not accepted as a valid course of treatment by the Utah Medical Association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

**Former Employee** means an Employee who has retired or terminated employment and who is eligible for continuation of coverage.

**Full-time Basis or Full-time Employment** means an Active Employee of the Employer; an Employee is considered to be Full-time if he or she normally works at least 20-40 hours per week and is on the regular payroll of the Employer for that work.

**Grace Period** means the period that shall be granted for the payment of any policy charge, during which time the policy shall continue in force. In no event shall the Grace Period extend beyond the date the policy terminates.

**He or Him** includes and means she or her.

**Insured** means an eligible person who enrolled with EMI Health through the Employer's group to receive covered services and who is recognized by EMI Health as an Insured. Employees/retirees of the Employer who are eligible to become Insureds can choose to enroll Dependents who satisfy EMI Health's Dependent eligibility requirements. In situations requiring consent, payment, or some other action, references to "Insured" include the parent or guardian of a minor or disabled Insured on behalf of that Insured.

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***Lifetime Maximum Benefit*** means the maximum amount of benefits paid by EMI Health that will be allowed under this Plan whether accumulated under this policy or any combination of policies administered by EMI Health. Amounts paid under a previous dental care plan, whether administered by EMI Health or any other carrier, for orthodontic benefits will be deducted from the maximum amount payable for orthodontic benefits under this Plan.

***Medically Necessary*** or ***Medical Necessity*** means health care services or product that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is

- In accordance with generally accepted standards of medical practice in the United States;
- Clinically appropriate in terms of type, frequency, extent, site, and duration;
- Not primarily for the convenience of the patient, physician, or other health care Providers; and
- Covered under the contract.

When a medical question-of-fact exists, Medically Necessary shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective. For interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established interventions, the effectiveness shall be based on Scientific Evidence, professional standards, and expert opinion.

***Participating Provider*** means a health care practitioner operating within the scope of his license, i.e., physician, oral surgeon, Dentist, anesthetist, etc., or a facility operating within the scope of its license, who has contracted with the Plan to render covered services and who has otherwise met the criteria and requirements for participation in the Plan.

***Plan*** means EMI Health Choice Dental Plan.

***Policyholder*** the Policyholder as stated on the face page of the policy.

***Premium Assistance*** means assistance under Utah Code Title 26, Chapter 18, Medical Assistance Act, in the payment of premium.

***Primary Plan*** means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration.

***Provider*** means a health care practitioner operating within the scope of his license, i.e., physician, oral surgeon, Dentist, chiropractor, anesthetist, etc. Provider also means a facility operating within the scope of its license.

***Reliable Evidence*** means only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying the same drug, device, medical treatment, or procedure.

***Scientific Evidence*** means 1) scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or 2) findings, studies, or research conducted by or under the auspices of federal

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government agencies and nationally recognized federal research institutes. Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

**Secondary Medical Condition** means a complication related to an Exclusion from coverage in the Plan.

**Secondary Plan** means any plan that is not a Primary Plan.

**Special Enrollment** means the right of an individual to enroll during the plan year, rather than waiting for the next Open Enrollment period, if He has experienced a qualifying event (including marriage, divorce, birth, adoption, placement for adoption, loss of other insurance coverage, or approval to receive a Premium Assistance) under HIPAA or ERISA regulations. The Subscriber must complete a new enrollment form and submit it to EMI Health within 31 days of any change in coverage or status.

**Spouse** means the person to whom the Subscriber is lawfully married or the person to whom the Subscriber is lawfully recognized as a common law Spouse.

**Subrogation** means the right that EMI Health has by virtue of this contract, and also by virtue of common law, to recover from a third party, or other responsible insurance, monies that EMI Health has advanced or paid to or on behalf of an Insured, where such monies were paid as a result of an injury to the Insured that was the fault of the third party.

**Subscriber** means the individual employed by the Policyholder and enrolled with the Plan to receive covered services, through whom Dependents may also be enrolled with the Plan. Subscribers are also Insureds. The term Subscriber may include eligible early retirees.

**Summary of Benefits** means the outline of benefits as established by this policy.

**Table of Allowances** means the schedule for payment of Eligible Expenses established by EMI Health.

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# **EMI HEALTH**

**EDUCATORS MUTUAL INSURANCE ASSOCIATION OF UTAH  
EDUCATORS HEALTH CARE  
EDUCATORS HEALTH PLANS HEALTH  
EDUCATORS HEALTH PLANS LIFE, ACCIDENT, AND HEALTH**

## **NOTICE OF PRIVACY PRACTICES**

**Effective: March 1, 2012**

**If you participate in any of the following benefits:**

- **Medical Benefits**
- **Dental Benefits**
- **Vision Benefits**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

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## Section 1. Introduction

Educators Mutual Insurance Association of Utah and its affiliates listed above (“Health Plan”) are dedicated to maintaining the privacy of your health information. This Notice governs certain health insurance benefits that you may purchase from us (i.e., Medical, Dental, and Vision benefits).

The Health Plan is required by law to maintain the privacy of your personally identifiable health information or “Protected Health Information” (“PHI”) and to inform you about:

- how it uses and discloses your PHI;
- your privacy rights with respect to your PHI;
- the Health Plan’s duties with respect to your PHI;
- your right to file a complaint with the Health Plan or with the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Health Plan’s privacy practices.

The term “Protected Health Information” or “PHI” means all individually identifiable health information transmitted or maintained by the Health Plan, regardless of form (oral, written, electronic).

The Health Plan is required to comply with the terms of this Notice. However, the Health Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Health Plan, including PHI received or maintained prior to the change. If a privacy practice described in this Notice is changed, a revised version of this Notice will be provided to all individuals then covered under the Health Plan for whom the Plan still maintains PHI. The revised notice will be posted on the Health Plan’s website at [www.emihealth.com](http://www.emihealth.com) and will be sent to you via e-mail.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual rights, the duties of the Health Plan or the other privacy practices described in this Notice.

## Section 2. Notice of PHI Uses and Disclosures

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization. Please note that Utah Law may impose additional restrictions on how the Health Plan may use and/or disclose specific types of health information (e.g., health information that relates to HIV/AIDS, domestic violence/abuse and substance abuse and chemical dependency) beyond those described below. In other words, we may further restrict the uses and disclosures described herein for the types of information listed above, where required by state law in Utah.

### A. Required PHI Uses and Disclosures

Upon your request, the Health Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Health Plan's compliance with the privacy regulations.

The Health Plan may contract with business associates for certain services related to the Health Plan. PHI about you may be disclosed to these business associates so that they can perform contracted services. To protect your PHI, each business associate is required to appropriately safeguard your PHI.

The following categories describe the different ways in which the Health Plan (and its business associates, as applicable) may use and disclose your PHI.

### B. Uses and disclosures to carry out treatment, payment and health care operations

The Health Plan may use and disclose your PHI to carry out treatment, payment and health care operations.

*Treatment* is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

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For example, the Health Plan may disclose to a treating specialist the name of your physician so that the specialist may ask for your lab results from the primary care physician.

*Payment* includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

For example, the Health Plan may inform a physician whether you are eligible for coverage or what percentage of the bill will be paid by the Health Plan.

*Health care operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Health Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

The Health Plan may also use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

#### *C. Authorized uses and disclosures*

You must provide the Health Plan with your written authorization for the types of uses and disclosures that are not identified by this Notice or permitted or required by applicable law. In addition, your written authorization generally will be obtained before the Health Plan will use or disclose psychotherapy notes about you from your mental health professional. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Health Plan may use and disclose such notes when needed by the Health Plan to defend against a legal action or other proceeding filed by you, and in other limited instances, without your written authorization.

Any authorization you provide to the Health Plan regarding the use and disclosure of your health information may be revoked at any time in writing. After you revoke your authorization, the Health Plan will no longer use or disclose your PHI for the reasons described in the authorization, except for the two situations noted below:

- The Health Plan has taken action in reliance on your authorization before it received your written revocation; or
- You were required to give the Health Plan your authorization as a condition of obtaining coverage.

#### *D. Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release*

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

#### *E. Uses and disclosures for which consent, authorization or opportunity to object is not required*

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or

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condition, if authorized by law. PHI may also be disclosed to a public health authority authorized to receive reports of child abuse, under certain circumstances.

- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Health Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met.
- For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person, provided certain requirements are met. The Health Plan may also disclose PHI about an individual who is or is suspected to be a victim of a crime, under certain circumstances.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- For research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct if the Health Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

### **Section 3. Rights of Individuals**

#### *A. Right to Request Restrictions on PHI Uses and Disclosures*

You may request that the Health Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Health Plan is not required to agree to your request.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

If you wish to make a request to restrict uses and disclosures of your PHI, you should make your request at the address listed at the end of this Notice.

#### *B. Right to Request Communications by Alternative Means/Locations*

The Health Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if you state that the disclosure of all or part of your PHI could endanger you.

You or your personal representative will be required to complete a form to request alternative communications.

If you wish to make a request for communications by alternative means, you should make your request to the address listed at the end of this Notice.

#### *C. Right to Inspect and Copy PHI*

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set" for as long as the Health Plan maintains the PHI.

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“*Designated Record Set*” includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan, or other information used by the Health Plan to make decisions about individuals.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

If you wish to make a request for access, you should make your request to the address listed at the end of this Notice.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. If the Health Plan is unable to meet this timeline, it may exercise a single 30-day extension under certain circumstances.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise review rights, if any, and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

*D. Right to Amend PHI*

You have the right to request the Health Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

If you wish to make a request to amend PHI, you should make your request to the address listed at the end of this Notice.

The Health Plan has 60 days after the request is made to act on the request. A single 30-day extension is permitted if the Health Plan is unable to comply with the deadline. If your request is denied in whole or part, the Health Plan must provide you with a written explanation of the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

*E. Right to Receive an Accounting of PHI Disclosures*

At your request, the Health Plan will also provide you with an accounting of disclosures by the Health Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to you about your own PHI; (3) prior to April 14, 2003; or (4) pursuant to your authorization.

If you request more than one accounting within a 12-month period, the Plan may charge a reasonable, cost-based health fee for each subsequent accounting.

You or your personal representative will be required to complete a form to request an accounting.

If you wish to make a request for an accounting, you should make your request to the address listed below at the end of this Notice.

If the Health Plan cannot provide you with an accounting within 60 days, a single 30-day extension is permitted, provided the health plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

*F. The Right to Receive a Paper Copy of This Notice Upon Request*

To obtain a paper copy of this Notice contact:

Privacy Officer  
EMI Health  
852 East Arrowhead Lane  
Murray, Utah 84107-5298

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Telephone: Salt Lake City (801) 262-7476  
Outside Salt Lake City (800) 662-5850  
Outside Utah (800) 548-5264

*G. A Note About Personal Representatives*

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- proof that the individual is the parent of a minor child.

The Health Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

**Section 4. Your Right to File a Complaint With the Plans or the HHS Secretary**

If you believe that your privacy rights have been violated, you may complain to the Health Plan in care of:

Privacy Officer

EMI Health  
852 E. Arrowhead Lane  
Murray, Utah 84107

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

The Health Plan will not retaliate against you for filing a complaint.

**Section 5. Whom to Contact at the Plan for More Information**

If you have any questions regarding this Notice or the subjects addressed in it, or would like to exercise one or more of your individual rights you may contact:

Privacy Officer  
EMI Health  
852 E. Arrowhead Lane  
Murray, Utah 84107  
Contact: Privacy Officer

Telephone: Salt Lake City (801) 262-7476  
Outside Salt Lake City (800) 662-5850  
Outside Utah (800) 548-5264